STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445360	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA HEALTH CARE-TENNOVA TCU	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility protocol, and interview, the facility failed to notify the physician of the development of a stage two	F 157	F157 1. Resident 143 was a closed record. 2. November 22, 2013 all records of 100% of current residents were audited to ensure proper physician, resident, resident's legal representative or interested family have been notified of any significant changes in the resident's condition. As a result of the audit, no residents were found to be affected by the deficient practice. 3. A. All staff will receive education related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition by no later than December 15, 2013. B. Physician, Physician Extender education will be conducted related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition by no later than December 15, 2013. C. A Physician Notification of Change in Condition sheet will be added as part of medical record documentation. This document will serve as notification to the physician/ physician extender of any noted changes in the condition of the resident. It will be placed in the Progress Notes for the physician/ physician extender to address accordingly. Also included on this document will be verification the resident, legal representative or interested family have been notified. Staff and Physician, Physician Extender education will be conducted and the document implemented for use by December 15, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Pamela B. Rogers RN/MSN | NHA | 11/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 pressure ulcer for one resident (#143) of six residents reviewed for pressure ulcer of twenty residents reviewed. The findings included: Resident #143 was admitted to the facility on September 6, 2013, with diagnoses including Diabetes, Hypertension, Autoimmune Idiopathic Immune-Mediated Thrombocytopenia, Pulmonary Contusion, Status Post Motor Vehicle Accident, and Multiple Fractures. Medical record review of a nurse's note dated September 11, 2013, revealed "...2nd (second) stage area noted..." Medical record review revealed no documentation the physician had been notified of the development of the Stage II pressure ulcer. Review of facility protocol, Wound and Skin Care, revealed " Protocol...Stage Two Pressure Ulcer: Needs MD Order..." Interview with the Director of Nursing on November 14, 2013, at 12:45 p.m., in the conference room confirmed 2nd stage area noted is Stage II pressure ulcer. Continued interview with the Director of Nursing on November 14, 2013, at 12:50 p.m., in the conference room, confirmed the pressure ulcer was identified on September 11, 2013. Further interview confirmed the physician had not been notified timely of the development of the pressure ulcer and no orders were received until September 14, 2013.	F 157	4. A. Random monthly audits of 20% of resident charts will be conducted starting in December 2013, to continue thereafter. B. All staff will receive annual education related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition on an annual basis as part of the mandatory Annual Review required for nursing staff.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 2 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Admission Minimum Data Set (MDS) was accurate for one resident (#143) of twenty residents reviewed. The findings included:	F 278	**F278** 1. On November 25, 2013 a *Section X Correction Request* was submitted to CMS to address the Coding Error related to the missing Stage II PrU noted on September 11, 2013 (Resident 143). 2. An audit of MDS's November 22-25, 2013 revealed no further inaccurate assessments. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist of MDS review by team for accuracy. B. Documentation will be revised by December 15, 2013 to include enhance the ability to correctly code for MDS accuracy. This documentation will include revised Nursing Notes and Physician Notification of Change in Condition. C. All staff will be educated on how to utilize and document on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident MDS will be conducted to monitor for accuracy starting in December 2013, to continue thereafter.	

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F 278	Continued From page 3 Resident #143 was admitted to the facility on September 6, 2013, with diagnoses including Diabetes, Hypertension, Autoimmune Idiopathic Immune-Mediated Thrombocytopenia, Pulmonary Contusion, Status Post Motor Vehicle Accident, and Multiple Fractures. Medical record review of a nurse's note dated September 11, 2013, revealed "... 2nd (second) stage area (Stage II pressue ulcer) noted..." Medical record review of the Admission MDS dated September 13, 2013, revealed no documentation of the Stage II pressure ulcer. Interview with the Director of Nursing on November 14, 2013, at 12:50 p.m., in the conference room confirmed the Admission MDS dated September 13, 2013, did not include the Stage II pressure ulcer.	F 278		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop an Admission Care Plan to address dental needs, depression, skin care, nutritional needs, psychotropic medications, dehydration, anticoagulant therapy, or pain control for seven (#182, #185, #140, #152, #188, #186, #180) of twenty residents reviewed.	F 281	F281 1. Residents identified who were present in the facility and not discharged and lacked appropriate Care Plans, were assessed and individualized Care Plans were initiated. 2. November 22, 2013 all records of 100% of current residents were audited to ensure admission Care Plans included necessary actual/potential problems, goals and approaches. Any residents identified to have Care Plan needs which were not documented were corrected and Care Plans were initiated. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist of Care Plan review by team for accuracy. B. Documentation will be revised by December 15, 2013 to include enhance the ability to identify Care Plan needs. This documentation will include revised Nursing Notes and Physician Notification of Change in Condition. C. All staff will be educated on how to utilize and document on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident Care Plans will be conducted to monitor for individualization and addressing of actual/ potential problems starting in December 2013, to continue thereafter.	

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F 281	Continued From page 4 The findings included: Resident #182 was admitted to the facility on November 8, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, Diabetes Mellitus, Hypertension, Depression, Anxiety, Degenerative Joint Disease, Hyperlipidemia, Peripheral Vascular Disease, and History of Pulmonary Embolism. Medical record review of the Nutrition Assessment dated November 11, 2013, revealed the resident had difficulty with chewing or swallowing, had missing teeth, and received a 2000 calorie diet. Medical record review of a hospital History and Physical dated October 29, 2013, revealed "...has chronic pain syndrome and takes narcotics...was given Narcan (antidote for narcotics)..." Medical record review of the facility's History and Physical dated November 8, 2013, revealed "...chronic pain syndrome...depression, anxiety...feels very depressed...Medications: At the present time...Trazodone (antidepressant) 100 mg (milligrams) p.o. (by mouth) at bedtime...Morphine extended release 50 mg p.o. 4 times a day...Altered mental status secondary to excessive narcotics. Currently, much more clear...does have chronic pain syndrome..." Medical record review of the Admission Care Plan dated November 8, 2013, revealed no documentation to address the resident's dental needs, depression, or pain control. Observation and interview with the resident on November 13, 2013, at 1:45 p.m., revealed the	F 281		

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F 281	Continued From page 5	F 281		

resident lying on the bed, in the resident's room, and stated 'My teeth hurt at times and are broken." Observation revealed the resident had three upper teeth and stated had "broken lower teeth." Continued interview with the resident revealed the resident had difficulty chewing due to missing teeth.

Interview with the Director of Nursing on November 14, 2013, at 10:10 a.m., in the conference room confirmed an Admission Care Plan had not been developed to address the resident's dental needs, depression, or pain.

Resident #185 was admitted to the facility on November 9, 2013, with diagnoses including Open Reduction and Internal Fixation of the Right Distal Femur, and Right Humeral Head Fracture.

Medical record review of the nursing notes dated November 10, 2013, revealed the resident required extensive assistance of two or more persons for bed mobility and transfers.

Medical record review revealed no documentation of the total score of the Braden Scale for Predicting Pressure Ulcer Risk had been completed to determine the resident's risk for development of pressure ulcers.

Medical record review of the Admission Care Plan dated November 9, 2013, revealed no documentation to address the resident's risk for the potential for the development of skin issues.

Observation with Licensed Practical Nurse (LPN) #1 on November 14, 2013, at 3:45 p.m., revealed the resident lying on the bed. Continued observation revealed two staff members assisted

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F 281	Continued From page 6 the resident to turn to the left side revealing the right leg had an immobilizer brace in place. Continued observation revealed a reddened area on the buttocks described as "blanchable." Interview with the Director of Nursing and the Administrator on November 14, 2013, at 2:50 p.m., in the nursing station revealed the resident was at risk for the development of pressure ulcers and confirmed the Admission Care Plan did not address the resident's risk for skin breakdown. Resident #140 was admitted to the facility on July 25, 2013, with diagnoses including Rhabdomyolysis, Hypertension, and Dehydration. The resident was discharged on August 1, 2013. Medical record review of the hospital History and Physical dated July 22, 2013, revealed "...weakness, likely secondary to dehydration...will hydrate..." Medical record review of the Discharge Summary from the hospital dated July 25, 2013, revealed "...electrolytes within normal limits...did not develop any renal dysfunction..." Medical record review of the Admission Care Plan dated July 25, 2013, revealed the Admission Care Plan had not been developed to include dehydration/fluid maintenance. Interview with the Director of Nursing (DON), on November 14, 2013, at 9:20 a.m., in the conference room confirmed the Admission Care Plan had not been developed for the dehydration.	F 281		

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F 281	Continued From page 7	F 281		

Resident #152 was admitted to the facility on August 29, 2013, with diagnoses including Chronic Kidney Disease, Hypertension, Coronary Artery Disease, and Hyperlipidemia. The resident was discharged on September 17, 2013.

Medical record review revealed no Admission Care Plan had been developed for the resident.

Interview with the DON on November 13, 2013, at 1:15 p.m., in the conference room confirmed an Admission Care Plan had not been developed for the resident.

Resident #188 was admitted to the facility on November 4, 2013, with diagnoses including Cerebrovascular Accident, Hypertension, Dementia, and Anxiety.

Medical record review of the physician's orders dated November 4, 2013, revealed "...Risperidone (antipsychotic) 0.25 mg (milligrams)...oral twice a day...citalopram (antidepressant) 40mg oral once a day..."

Medical record review of the Admission Care Plan dated November 4, 2013, revealed no development on the Admission Care Plan for the use of psychotropic drugs.

Medical record review of the Braden scale score dated November 4, 2013, revealed the resident was at risk for the development of pressure ulcers.

Medical record review of the Admission Care Plan dated November 4, 2013, revealed no care plan had been developed for the potential alteration in skin integrity.

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F 281	Continued From page 8 Interview with Registered Nurse #3, on November 14, 2013, at 9:15 a.m., in the Minimum Data Set (MDS) office confirmed the Admission Care Plan had not been developed to include the psychotropic drug use. Interview with the DON on November 14, 2013, at 3:10 p.m., in the conference room confirmed the resident was at risk fo the development of pressure ulcers and the Admission Care Plan had not been developed for the potential alteration in skin integrity. Resident #186 was admitted to the facility on October 31, 2013, with diagnoses including Acute Respiratory Failure, Exacerbation of Chronic Obstructive Pulmonary Disease, with history of Coronary Artery Disease with Coronary Artery Bypass Grafting, Atrial Fibrillation, Peripheral Vascular Disease, Diabetes Mellitus, and Decubitus Ulcers. Observation and interview with the resident in the resident's room on November 12, 2013, at 10:55 a.m., revealed the resident lying on the back and complaining of pain in the legs. Medical record review of the Medication Administration Record dated November 2013 revealed the resident received Hydrocodone 5 milligrams every 4 hours as needed. Medical record review revealed the resident received the narcotic pain medication at least twice daily. Medical record review revealed no Admission Care Plan had been developed to address pain. Medical record review of the Physicians orders	F 281		

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F 281	Continued From page 9 dated October 31, 2013, revealed an order for Pradaxa (anticoagulant/blood thinner) 150 milligrams twice a day. Medical record review of the electronic Medication Administration Record revealed the resident had received the Anticoagulant as ordered. Medical record review revealed no Admission Care Plan had been developed to address the issue of the Anticoagulant or risk of bleeding. Interview with the Director of Nursing in the hallway charting area, on November 13, 2013, at 2:40 p.m., confirmed the facility had failed to develop a care plan to address the risk of bleeding and pain. Resident# 180 was admitted to the facility on November 9, 2013, with diagnoses of Epidural Abscess, Cervical Osteomyelitis, Chronic Obstructive Pulmonary Disease, and Endocarditis. Medical record review of the resident's admission care plan dated November 9 ,2013, revealed no care plan for dental care or nutrition. Medical record review of the nursing admission assessment dated November 9, 2013, revealed "...oral assessment: very poor dentation, dietary referral: yes..." Medical record review of a dietary admission note dated November 11, 2013, revealed "...appetite very good, admission weight of 139.5# (pounds), height 76" (inches), BMI (body mass index, normal values are 22 and above) 21.8; IBW (ideal body weight) 148; moderate nutritional risk > (less than) 75% (percent) of meals consumed..."	F 281		

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F 281	Continued From page 10 Interview with the resident on November 13, 2013, at 2:09 p.m., in the resident's room revealed the resident had been missing many teeth for 18 years. Interview with the DON on November 13, 2013, at 3:05 p.m., in the conference room confirmed the resident had not been care planned for nutrition or dental status.	F 281	**F314** 1. A. Physician orders were obtained for any resident identified, that was still present in the facility and not discharged, who were receiving facility protocol for pressure ulcers. B. The dietician was alerted to initiate an assessment. C. Pressure ulcer risk assessments were completed for identified residents still in the facility and not discharged.	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, review of facility protocol, observation, and interview, the facility failed to properly assess pressure ulcers, failed to follow facility protocol for notifying the dietician for a resident with a pressure ulcer, failed to obtain physician's orders for the treatment of a pressure ulcer, and failed to complete a pressure ulcer risk assessment for four (#152, #143, #186, #185) of six residents reviewed for pressure ulcers of twenty residents reviewed.	F 314	2. November 22, 2013 all records of 100% of current residents were audited to ensure any resident with skin integrity problems, actual or potential, had physician orders for treatments, dietician consults and Pressure Ulcer Risk Assessments. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist a review of skin integrity problems, actual or potential by team to ensure any resident with skin integrity problems, actual or potential, had physician orders for treatments, dietician consults and Pressure Ulcer Risk Assessments. B. Documentation will be revised by December 15, 2013 to include a weekly skin audit, Physician Notification of Change in Resident Condition, dietary consults and Physician Orders. C. All staff will be educated on how to properly assess, plan, implement and document skin care on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident records will be conducted to monitor for Physician Notification of Change in Condition, Physician Orders and Dietary Consults starting in December 2013, to continue thereafter.	

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F 314	Continued From page 11 The findings included: Resident #152 was admitted to the facility on August 29, 2013, with diagnoses including Chronic Kidney Disease, Hypertension, Coronary Artery Disease, Debility, and Hyperlipidemia. The resident was discharged on September 17, 2013. Medical record review of a nursing note dated September 10, 2013, revealed "...Skin Assessment...Buttocks red...Braden Scale Score 18 (18 or less are considered to be at risk of developing pressure ulcers)." Medical record review of a nursing note dated September 14, 2013, revealed "...Buttocks...Optifoam to stage II..." Medical record review of a nursing note dated September 15, 2013, revealed "...Stage II on buttocks/coccyx cleaned (with) wound cleanser, pat dry, applied new duoderm (and) hydrogel to wound..." Medical record review of physician's orders dated August 29, 2013, revealed "...Multivitamin...1 tablet...oral once a day..." Medical record review of physician's orders dated September 6, 2013, revealed "...Nutritionist eval (evaluation)-TF (tube feeding) recommendations..." Medical record review of Nutrition Progress Notes dated September 7, 2013, revealed "...Rec (recommend) use of Jevity 1.2 (at) goal rate of 75 ml (milliliters)/hr (hour)...will follow and monitor progress..."	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 Medical record review of Nutrition Progress Notes dated September 16, 2013, revealed "...Chart, labs reviewed. Pt. (patient) tolerating TF well..." Medical record review of a nursing note dated September 17, 2013, revealed "...(dressing) on coccyx (and) buttocks (changed)..." Medical record review of physician's orders dated September 17, 2013, revealed "...D/C (discharge) to SNF (skilled nursing facility)...(stage) II (buttocks) per facility protocol..." Review of facility policy, Pressure Ulcer Prevention, revealed "...The admission assessment and daily assessment should include...a complete skin assessment. If the patient is identified as at risk on the Braden Scale (18 or lower), the nurse will make the physician aware of the risk and utilize skin care protocols...weekly wound measurements will be completed on patients with existing wounds and documented. When this is completed, the following will be documented for any wound assessment: location, stage of ulcer, size/depth, length and width of pressure ulcer, condition of surrounding skin, presence of tracts or undermining, and ulcer bed appearance...Implement skin care orders as appropriate..." Review of facility protocol for pressure ulcers revealed "...Stage II...Needs MD order...Measure: Wound Area Dry to scant drainage Apply...Hydrogel Gel cover: Exuderm...Change every 3-5 days and at least weekly...Moderate to heavy drainage Apply: Maxorb...cover: Optifoam Adhesive...Change every 3-5 days and at least weekly...Obtain nutritional consult..."	F 314		

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F 314	Continued From page 13 Interview with the Director of Nursing (DON), on November 13, 2013, at 3:30 p.m., in the conference room confirmed no orders had been obtained for the treatment of the pressure ulcer and no complete assessment had been completed on the pressure ulcer. Interview with the DON on November 14, 2013, at 12:50 p.m., in the hall confirmed the Certified Nursing Assistants (CNA's) apply barrier cream to bedbound or incontinent residents. Interview with Registered Nurse (RN) #1 on November 14, 2013, at 1:20 p.m., by telephone confirmed the buttocks were red and blanchable on September 10, 2013. Continued interview with RN #1 confirmed the resident only had one pressure ulcer at the top of the buttocks. Resident #143 was admitted to the facility on September 6, 2013, with diagnoses including diabetes, Hypertension, Autoimmune Idiopathic Immune-Mediated Thrombocytopenia, Pulmonary Contusion, Status Post Motor Vehicle Accident, and Multiple Fractures. The resident was discharged on September 29, 2013. Medical record review of the skin assessment on the nursing note dated September 11, 2013, revealed "...2nd stage area (Stage II pressure ulcer noted...(no documentation of the assessment of the Stage II pressure ulcer)." Medical record review of nurse's notes from September 12, 2013 through September 14, 2013, revealed skin assessment of buttocks was within normal limits, or no skin assessment completed.	F 314		

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F 314	Continued From page 14 Medical record review of a physician's order dated September 15, 2013, revealed "...Sore/reddened area on bottom - c/w (clean with) EPC (barrier) cream..." Medical record review of a nursing note dated September 15, 2013, revealed "...buttocks red - barrier cream..." Medical record review of a physician's order dated September 18, 2013 revealed "...protocol to left buttock..." Medical record review of the nursing note dated September 19, 2013, revealed, "...Optifoam D/I (dry/intact)..." Medical record review of a nurse's note dated September 24, 2013, revealed "...Stage II Bilateral Buttocks, Optifoam D/I...(no assessment of the Stage II pressure ulcer on the bilateral buttocks)." Medical record review of a physician's order dated September 27, 2013, revealed "... Apply 4x4 Exuderm to open areas, Q (change) every 72 hours and prn (as needed) after BM (bowel movement)." Medical record review of a nurse's note dated September 27, 2013, revealed "...Exuderm...4x4 applied to (bilateral) buttocks open areas, ST. (stage) II (after) cleansing with wound cleanser and patted dry..." Medical record review of a nutrition progress note dated September 27, 2013, revealed "...Reports fair appetite...intake 50-100% overall... will add	F 314		

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F 314	Continued From page 15 ensure to trays...(sixteen days after Stage II pressure ulcer noted)." Interview with Director of Nursing on November 14, 2013, at 12:50 p.m., in the conference room confirmed a complete assessment of the pressure ulcer had not been completed and a nutritional assessment had not been completed timely. Resident #186 was admitted to the facility on October 31, 2013, with diagnoses including Acute Respiratory Failure, Exacerbation of Chronic Obstructive Pulmonary Disease, with history of Coronary Artery Disease with Coronary Artery Bypass Grafting, Atrial Fibrillation, Peripheral Vascular Disease, Diabetes Mellitus, and Decubitus Ulcers. Medical record review of the admission orders dated October 31, 2013, revealed an order for Wound Care indicating the facility protocol to be implemented. Medical record review of the Physician's orders titled, Pressure Ulcer Treatment protocol, dated November 7, 2013, revealed, "Consult dietary for Nutritional Assessment with wound healing guidelines...Use heel and elbow protectors..." Medical record review of the facility Admission Routine record dated October 31, 2013, revealed the System Assessment documentation indicated the resident was admitted with swelling, wound, scar, rash, ecchymosis, drainage and poor turgor. Further review revealed the resident was admitted with 2 "ulcers/pink tissue" on the left buttock; 2 "ulcers/pink tissue" on the right buttock; and one "sacral wound 1cm (centimeter)	F 314		

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F 314	Continued From page 16 deep 1 ½ cm wide." Review of the record revealed the sacral wound had developed the presence of a tunnel. Continued review of the record revealed the wounds on the buttocks were not staged or measured, and the sacral wound was not staged and the length was not measured. Medical record review of the facility Admission Routine form dated October 31, 2013, revealed the resident scored a "12" on the Braden Scale. Medical record review of the nursing documentation dated November 14, 2013, revealed, "1100 changed dressing on sacrum. Sacral wound is 1 cm deep, 1 cm long, and 1 cm wide. The wound on the right buttocks is ½ cm wide and 1 cm long. The wound to the side of that one is 1 quarter of an inch wide and ½ cm long. The wound on the left buttocks is 1 1/2 cm long and 1 cm wide. The other wound on the left buttock is ½ cm wide and 1 cm long. The buttocks are excoriated 16 cm wide and 20 cm long..." Medical record review revealed no documentation of the evaluation or measurements of the wounds since admission (14 days). Observation of the dressing change for resident #186 on November 14, 2013, at 11:00 a.m., revealed the resident continued to have 5 wounds to the buttock and sacral area. Continued observation revealed the resident did not have elbow or heel protectors in use. Interview with Registered Nurse (RN) #2, (the nurse who changed the dressing and documented) on November 14, 2013, at 2:48	F 314		

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F 314	Continued From page 17 p.m., confirmed the wound on the sacrum was a stage III and the wounds on the buttocks were a stage II. Interview with Certified Nursing Assistant (CNA #1) on November 14, 2013, at 11:35 a.m., in the hallway confirmed the resident did not have heel or elbow protectors in use. Interview with the Director of Nursing on November 14, 2013, at 12:31 p.m., at the hallway charting area confirmed the facility had failed to measure and assess wounds on admission and for the following 14 days; failed to notify dietary for a nutritional assessment; and failed to implement the use of heel and elbow protectors. Resident #185 was admitted to the facility on November 9, 2013, with diagnoses including Open Reduction and Internal Fixation of the Right Distal Femur, and Right Humeral Head Fracture. Medical record review of the nursing notes dated November 10, 2013, revealed the resident required extensive assistance of two or more persons for bed mobility and transfers. Medical record review revealed no documentation of the scoring of the Braden Scale for Predicting Pressure Ulcer Risk had been completed. Observation with Licensed Practical Nurse (LPN) #2 on November 14, 2013, at 3:45 p.m., revealed the resident lying on the bed. Continued observation revealed two staff members assisted the resident to turn to to the left side revealing a reddened area on the buttocks described as "blanchable."	F 314		

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F 314	Continued From page 18 Interview with the Director of Nursing and the Administrator on November 14, 2013, at 2:50 p.m., in the nursing station revealed the resident was at risk for the development of pressure ulcers and confirmed there was no scoring of the Braden Scale to indicate if the resident was at risk for the development of pressure ulcers.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	**F356** 1. Daily nurse staffing was immediately posted as required. 2. The daily nurse staffing has been monitored daily since the November 12, 2013 noted deficiency. 3. 11 p.m. – 7 a.m. Charge Nurse and 7 a.m. – 3 p.m. Charge include the posting of daily nurse staffing as part of shift report to ensure compliance. 4. Random audits will be performed 3 times per week to ensure staffing is posted as required. _____	

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F 356	Continued From page 19 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nurse staffing data was posted on a daily basis at the beginning of each shift. The findings included: Observation on November 12, 2013, at 8:20 a.m., during the initial tour revealed nurse staffing was posted at the nurse's station and the document was blank. Interview with Licensed Practical Nurse (LPN) #1, on November 12, 2013, at 8:30 a.m., in the nurse's station confirmed the facility failed to complete the nurse staffing data for November 12, 2013.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F441** 1. Student was immediately re-educated to proper infection control procedures. The student was required to submit a written essay related to the importance of infection control Instructor was immediately re-educated to proper infection control procedures. 2. A review of the census revealed no other residents were in isolation and no other residents were identified to be affected. 3. By December 15, 2013 all staff will be re-educated via classroom in service on proper infection control protocol. 4. 2 Staff will be randomly quizzed on a monthly basis beginning December 20, 2013 to assess their knowledge base related to infection control. Any staff not able to express proper protocol will be re-educated. Education will be provided on an annual basis in the computer based learning modules.	

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F 441	Continued From page 20 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to clean equipment to prevent cross contamination for one of one isolation room. The findings included: Observation on November 12, 2013, at 10:15 a.m., revealed nursing student #1 exited the resident's room carrying a pulse oximeter, blood pressure cuff, and stethoscope on the clipboard in hand. Continued observation revealed the resident room was designated by sign and	F 441		

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F 441	Continued From page 21 equipment as a Contact Isolation room. Continued observation revealed the student nurse wiped the equipment with alcohol pads. Review of the facility policy, Cleaning and Disinfecting of Equipment, dated August 24, 2012, revealed "Procedure: ...#2. Follow manufacturer instructions for the type of cleaning and disinfecting solutions recommended, or use hospital approved solution." Interview with Director of Nursing (DON) in the medication room on November 13, 2013, at 8:45 a.m., confirmed the hospital approved solution for cleaning equipment taken into an isolation room was Cavi (bleach) wipes. Interview with the Registered Nurse (nursing instructor) in the hallway on November 13, 2013, at 9:19 a.m., confirmed the nursing instructor was not present when the nursing student exited the isolation room. Continued interview confirmed the student had failed to use the approved method of cleaning equipment according to facility policy.	F 441		